STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES

Medical Use of Marijuana Program

Caregiver Application

SECTION 1: Caregiver Information	**New Applicant** ☐	**Renewal** ☐	**Adding Patient (Max of 5)** ☐
Legal Name:			
Date of Birth:	Telephone No.: ( )		
Home Address:			
City:	State:	Zip:	
Mailing Address:			
City:	State:	Zip:	
Email Address:			

SECTION 2: Fees	
APPLICATION FOR CAREGIVER	
License Type (Select One): ☐ Nursing Facility - No Fee ☐ Hospice - No Fee ☐ Primary Caregiver (NOT growing marijuana) - Mandatory $31 fee for background checks ☐ Primary Caregiver (Growing marijuana) – Please complete below: Number of patients (maximum of 5): _____ multiplied by $300 cultivation fee = Caregiver Criminal Background Check: $31.00 (Mandatory Annually) **The only exceptions for the $300 cultivation fee are found in the Rules Governing the Maine Medical Use of Marijuana Program Section 5.4** **If one of the exceptions apply, please identify the patient/caregiver relationship _____**	$ _____ $ _____ $ _____
Make check or money order payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. **Total Check/Money Order enclosed: =**	**$ _____**

For questions regarding this program and/or application, please contact the following:
Department of Health and Human Services
Licensing and Regulatory Services
Maine Medical Use of Marijuana Program
41 Anthony Ave; 11 State House Station
Augusta, ME 04333-0011
Tel: (207) 287-4325 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: medmarijuana.dhhs@maine.gov

Office Use Only:
Check# _____ *MO #* _____ *Amount $*_____ *Initials:* _____ *License#* _____

SECTION 3: Card Renewals

1. Registration # _____ Control # _____
2. Registration # _____ Control # _____
3. Registration # _____ Control # _____
4. Registration # _____ Control # _____
5. Registration # _____ Control # _____

SECTION 4: Grow Location (If applicable, to be completed by cultivating caregiver)

Address/Grow location:

City:	State:	Zip:	County:

☐ **Enclosed, locked facility** means a closet, room, building, greenhouse or other enclosed area that is equipped with locks or other security devise that permits access only by an individual authorized to cultivate the marijuana. (Section 2.7.1)

☐ **Fence.** An enclosed outdoor area must have a privacy fence at least 6 feet high that obscures the view of the marijuana to discourage theft and unauthorized intrusion. When this height requirement is inconsistent with local ordinances regarding fences, deference is given to local ordinance height requirements. Qualifying patients or caregivers must comply with local ordinances, if any, regarding boundary setback requirements. (Section 2.7.1.1.1)
Describe how your grow location meets this requirement:

Prepared Edibles. Indicate whether you will prepare edibles containing marijuana: ☐ No ☐ Yes

If yes, have you met the requirements for a food establishment? (Section 5.7-Food Establishment License)

☐ Yes (Please attach evidence) ☐ No

SECTION 5: Nursing Facility or Hospice Information (if applicable, to be completed by Chief Executive Officer)

Legal Name of Facility:

Mailing Address:

City:	State:	Zip:	County:

Name and Title of Chief Executive Officer:

Telephone No.: ( )	Email Address:

SECTION 6: Submission

Remember to submit the following documents with your completed application:

- A check or money order made payable to "Treasurer, State of Maine"
- Copy of the Caregiver's current Maine Driver's License or Other Maine Issued Photographic Identification Card
- Evidence of eligibility as a food establishment, if applicable

SECTION 7: Declaration

- I UNDERSTAND and acknowledge my duties as a caregiver.
- I UNDERSTAND that my authorization to grow medical marijuana is contingent on my possessing a valid caregiver designation form for each patient for whom I grow medical marijuana.
- I AGREE to return the caregiver designation form to the patient if the patient informs me that he or she no longer wants me to be his or her caregiver.
- I ACKNOWLEDGE that I have only 10 days from that notice to either destroy excess marijuana or to replace the patient with a new patient.
- I AGREE that in the event that law enforcement questions my status as a caregiver, that I will make available for verification to law enforcement, copies of each caregiver designation form that I reply on to support the amount of medical marijuana in my possession.
- I UNDERSTAND that if I do not comply with any of these requirements, the Department of Health and Human Services can revoke the caregiver identification care assigned for that patient.
- I DECLARE under penalty of perjury that the information provided on this form is true and correct.
- I CERTIFY that I will not sell, furnish or give marijuana to a person who is not allowed to possess marijuana for medical purposes.
- I FURTHER AGREE that I will report sales tax related to the sale of marijuana by me to a qualifying patient.

_____	_____	_____
Print name of Caregiver	**Signature of Caregiver**	**Date**